Getting to Know

STAR+PLUS
Welcome

This course was developed by the Local Procedure Development and Support Section of the Texas Department of Aging and Disability Services. The policy information in this course is current as of May 2010.
Protected time is critical to your success in taking a computer based course.

Before you begin working on this course, close your door and let other staff know that you are in training.

Set aside approximately one hour of time to work on the course.
Sitting at a computer even one hour without taking short breaks can cause real pain!

Therefore, we recommend a break every 20 minutes or so. Take a break even if you only get up and walk a few minutes or grab a cup of coffee.
This course is divided into the following modules:

- Introduction
- Traditional Medicaid vs. Managed Care
- Nuts and Bolts of STAR+PLUS
- Eligibility Groups Included in STAR+PLUS
INTRODUCTION
Objectives

After completing this course, you will be able to:

- identify the differences between the traditional Medicaid service delivery model and the Managed Care service delivery model,

- identify the processes used in enrollment and case management of State of Texas Access Reform PLUS (STAR+PLUS), and

- identify the programs that require mandatory enrollment in STAR+PLUS.
Traditional Medicaid vs. Managed Care
In an effort to better understand how STAR+PLUS operates, let’s first take a look at the processes that are used in “traditional Medicaid” and the “original STAR” programs.
Medicaid is the State and Federal cooperative venture that provides medical coverage to eligible needy persons. The purpose of Medicaid in Texas is to improve the health of people who might otherwise go without medical care for themselves and their children.
Medicaid and Managed Care

It is important to note that with the implementation of managed care, Medicaid still exists. Only the method of service delivery changes.
In the traditional system, an eligible consumer accesses medical service providers directly. Providers submit their bills for payment directly to Texas Medicaid and Healthcare Partnership (TMHP), who is the contractor for the Health and Human Services Enterprise.
Things were working well
....weren’t they?

Keep going to find out…
The Texas Legislature determined that it was time to reform the traditional Medicaid system. Reasons for reform included:

- rising costs of medical care,
- needed improvements for access to care,
- needed improvements for delivery of care, and
- needed improvements in quality of care.

Let’s look at each of these in more detail.
Why reform Medicaid?

One reason to reform Medicaid is to **control increasing costs**.

- Medicaid costs continue to climb. Medicaid now represents over one quarter of the state budget.

Ref: Texas Medicaid in Perspective – Fifth Edition
A second reason to improve Medicaid is to **improve access to care**.

- The traditional Medicaid system does not guarantee that consumers will have a personal doctor. Many Medicaid consumers cannot locate a consistent source for medical care or a “medical home”.

- This often means that medical problems go untreated until they become severe enough to send the Medicaid consumer to the Emergency Room.
A third reason to reform Medicaid is to **improve the delivery system**.

- Traditional Medicaid does not coordinate care.
- Consumers are treated by various doctors who may not be aware of each other.
- Tests may be duplicated and prescribed treatments may conflict, creating problems for the consumer.
Why reform Medicaid?

A fourth reason for change is a need to focus on quality.

- For most Medicaid services, Medicaid has traditionally acted like an insurance company – paying claims for services if the claims met the program requirements.
- Little, if any effort was made to understand the outcomes of the care provided in order to try to improve health outcomes.
How do you reform Medicaid?

The Texas Legislature answered this question by requiring Managed Care as a major component of Medicaid Reform.
Managed Care is a general term for organizing doctors, hospitals and other providers into groups called Health Maintenance Organizations (HMOs) to enhance:

- access to health care,
- quality of health care, and
- cost-effectiveness of health care delivery.
Managed care as an industry has changed and evolved since its inception in the 1960s.

Managed care began as a means to contain medical costs. It has become a model of the best way to deliver the correct medical services, in the correct setting, to those in need of medical care.
History of Managed Care

Medicaid Managed Care has grown rapidly. In 1991, 2.7 million beneficiaries were enrolled in some form of managed care. By 2008, that number had grown to 33 million. This is 70.91% of the total Medicaid population.

Ref: Centers for Medicare and Medicaid Services-Medicaid Managed Care Trends
Why Managed Care?

- The HMO can be flexible with the dollars because it is getting a lump sum, known as a prospective capitated payment, each month for each person enrolled instead of a separate payment for rigidly defined categories of service.

- Quality improvement plans are a required feature of Medicaid managed care contracts.

- HMOs emphasize prevention – keeping people healthy and functioning as well as possible instead of waiting for a health crisis to occur.
How does STAR+PLUS save the state money?

- Medicaid managed care saves money by managing care and requiring members to go to their Primary Care Physician (PCP) also known as their medical home. This adds stability and predictability to the state budget compared to traditional fee for service Medicaid programs.

- Instead of paying high costs for individual services provided for a Medicaid consumer, the state will pay a monthly premium to the HMO for each Medicaid consumer who is a member of the HMO.
How does STAR+PLUS save the state money?

Let’s look at an example of Mrs. Millie Robbins, a Managed Care Medicaid consumer.

She saw her PCP who referred her to a specialist. The specialist ordered additional tests. Total expenses were $1,200.00.

Since she is a Managed Care consumer, the State of Texas paid her HMO a set premium to handle all of her medical care. If the expenses exceed the set premium, the HMO does not bill the state for those additional costs.
How does this profit the HMO?

- HMOs make money by dealing with health care needs early to help people maintain or improve their ability to function on a day-to-day basis. They also manage services knowing that some members’ services will cost more than others. The HMO will receive the capitated payment even if the member has no medical costs for that particular month.

Keep going to see an example.
How does this profit the HMO?

This example is of Mr. James Grayson. Mr. Grayson is a Managed Care Medicaid consumer.

The State of Texas paid the monthly premium to his HMO for his care. He has been feeling very well lately and required no medical care this month.

The HMO does not have to refund the monthly premium to the state.
State Savings vs. HMO Profits

As these examples show, there will be times when the HMO pays more than the premium that they received, resulting in savings for the state.

There will be other times when the HMO pays less than the premium that they received, resulting in a profit for the HMO.
Managed Care in Texas

As a result of the 1991 House Bill 7, Texas Department of Health (TDH) began offering managed health care to certain Medicaid eligible consumers in certain counties in Texas as a new Medicaid service delivery program.

The first pilot program was implemented August 1, 1993 in Travis County. This pilot program was called LoneSTAR (State of Texas Access Reform).

The program was implemented in other counties after the first pilot. The program continues today, but the name has been shortened to “STAR.”
The STAR Program covers what is commonly called “acute care.” These medical services include physician services, prescriptions, hospital care, and laboratory services.

The STAR Program emphasizes preventative health care and seeks to reduce visits to hospital emergency rooms, which is the most costly way to provide health services.

The STAR Program does not include Long Term Services and Supports.
Enrollment Assistance

The State contracts with an enrollment broker, who can be objective and is not connected to a HMO, to ensure consumers have sufficient information and assistance to make an informed choice. The enrollment broker ensures that consumers are informed about:

- HMO options, and
- enrollment procedures.
Once consumers select a HMO, they choose a PCP who is their “medical home.” The PCP must be in the HMO network. The PCP makes referrals to other providers affiliated with the HMO for other needed services and thus “manages” their care.

The state pays a monthly premium to the HMO for each consumer enrolled in the plan. The plan processes all provider claims, per Texas Department of Insurance rules.
In the STAR system, the Primary Care Physician acts as the gatekeeper and coordinates medical care.
So far, we’ve looked at the differences between Traditional Medicaid and the Original STAR program.

The changes did not stop there. The consumers in managed care were still limited in numbers.

In an effort to expand Managed Care in Texas, the Texas Legislature took another look…
Expansion of Managed Care

In an effort to expand Managed Care, legislators looked at the following statistics:

- Consumers who are aged or who have a disability make up about 20% of the Medicaid population in Texas.

- Expenditures for these consumers account for more than \( \frac{1}{2} \) of all Medicaid spending.

This group of consumers seemed the perfect target group for expansion of Managed Care.
The 74th Texas Legislature expanded Managed Care to include certain Medicaid consumers who are aged or who have a disability. The STAR+PLUS program was created as a managed care system which would combine Medicaid acute care with long-term services and supports.
In the next module, we will look at how STAR+PLUS operates.
Let’s Review…

- As a consumer of traditional Medicaid, Mr. Johnson must find his own physician. He might call several offices in his area that tell him they are not accepting new patients.

True or False
Let’s Review…

- As a consumer of traditional Medicaid, Mr. Johnson must find his own physician. He might call several offices in his area that tell him they are not accepting new patients.

True or False

This is true. One of the benefits of managed care is the provision of a Primary Care Physician.
Let’s Review…

- As a STAR Medicaid consumer, Mr. Tate must find a primary care physician that will take his new “insurance.”

  True or False

Keep going to find out.
Let’s Review…

- As a STAR Medicaid consumer, Mr. Tate must find a primary care physician that will take his new “insurance.”

  True or False

This is false. The HMO coordinates with all the providers who participate in their network and serves as the medical home.
Nuts and Bolts of STAR+PLUS
Two of the objectives of STAR+PLUS are to:

- improve access to care by increasing the number of providers that are available to be a medical home for the consumer, and
- emphasize prevention, which keeps members healthy through education and early care.

Keep going to find out more about these objectives.
Improved Access

STAR+PLUS improves access to services by:

- providing PCPs,
- providing access to a 24-hour nurse line, and
- requiring HMOs to contact all members to determine whether there is a need to conduct an assessment for LTSS services. HMOs are also required to conduct an assessment if the member requests one.
Prevention

- Consumers can receive annual wellness check-ups that are not currently covered by traditional Medicaid.
Benefits of STAR+PLUS

By combining acute care and long-term services and supports, there is more flexibility to meet the individual’s needs.

Keep going to see another important benefit—better coordination of care.
Benefits of STAR+PLUS

Another benefit of STAR+PLUS is service coordination, which entails the following:

- HMO nurses or social workers will be available to all members.
- Service coordinators who will:
  - make home visits to assess members’ needs,
  - authorize community Long-Term Services and Supports,
  - arrange for other services (e.g. medical transportation),
  - coordinate community supports (e.g. housing), and
  - coordinate with Medicare providers.
Let’s look at an example…

- Mrs. Morgan was unable to walk on her own. She required transportation to dialysis three times per week. Her home had no ramp, so she could not be taken outside in her wheelchair. Under the traditional Medicaid program, she had to be taken to dialysis on a stretcher by ambulance.

- Cost - $600.00 per trip
The rest of the story…

- After enrollment into STAR+PLUS, her HMO care coordinator determined that a ramp was the answer. A ramp was authorized. Because of this addition to her home, she was able to leave her home in her wheelchair.

- Cost: $20.00 per trip
As you can see from the example, the STAR+PLUS program provided a new option to meet Mrs. Morgan’s need.
STAR+PLUS Services

- HMOs are required to assess all (who request or are identified by referral or other contact) STAR+PLUS consumers to determine needs and to develop appropriate care plans.

- HMOs have an incentive to provide innovative, cost-effective care from the outset in order to prevent or delay the need for more costly institutionalization.
The following services are included in the STAR+PLUS model.

- Personal Assistance Services
- Day Activity and Health Services (Title XIX)
- 1915(c) Nursing Facility Waiver Services such as:
  - Adaptive Aids
  - Adult Foster Home
  - Assisted Living
  - Personal Attendant Services
  - Home Modifications
  - Nursing
  - Therapies
  - Home Delivered Meals
  - Medical Supplies
  - Emergency Response
Medication Services

Medications are not part of the HMO’s array of services.

“Medicaid only” enrollees/members will receive unlimited prescriptions through the state’s Vendor Drug Program and “Medicare/Medicaid” enrollees/members will receive prescriptions through the Medicare RX Prescription Drug Program.
Pilot of STAR+PLUS

- The voluntary pilot of STAR+PLUS began in Harris County on January 1, 1998.

- The mandatory pilot of STAR+PLUS began in Harris County on April 1, 1998.
Time to Expand

- The state’s goal was to expand STAR+PLUS to other areas of the state.
- Effective February 1, 2007 STAR+PLUS expanded to cover the following service areas*:
  - Travis Service Area
  - Harris Service Area
  - Nueces Service Area
  - Bexar Service Area
  *Service areas include surrounding counties.
STAR+PLUS
Managed Care Service Areas
With HHSC Regions (in red)

Core Service Areas in STAR+PLUS
A New Expansion

The 2010-11 General Appropriations Act, required HHSC to implement the most cost-effective managed care model for the population in the Dallas/Tarrant service areas. HHSC’s decision was to implement STAR+PLUS in response to the legislative mandate.

The proposed expansion date is February 2011.
STAR+PLUS Proposed Expansion

Proposed STAR+PLUS Service Areas
With HHS Regions (in red)

<table>
<thead>
<tr>
<th>Service Area</th>
<th>County</th>
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</thead>
<tbody>
<tr>
<td>Dallas</td>
<td>Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall</td>
</tr>
<tr>
<td>Tarrant</td>
<td>Denton, Hood, Johnson, Parker, Tarrant, Wise</td>
</tr>
</tbody>
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Tarrant SA
Dallas SA
Previously, we discussed the process of selecting the HMO and the “medical home” (PCP).

It is important to note that there is a difference between Medicaid only and Medicaid/Medicare consumers when selecting a PCP.

Medicaid/Medicare consumers will select a HMO, but will not choose a PCP. They will receive their acute care through their Medicare providers. They will receive long-term services and supports only from the HMO. They will continue to receive service coordination from the HMO, but there is no impact on how the member obtains Medicare services.
The following module discusses eligibility groups affected by STAR+PLUS and how case management will work.
Let’s Review…

- Medicaid managed care programs save money and add stability and predictability to the state budget compared to traditional fee for services Medicaid programs.

  True or False

Keep going to find out.
Let’s Review…

- Medicaid managed care programs save money and add stability and predictability to the state budget compared to traditional fee for services Medicaid programs.

True or False

This is true. The state will only make a single payment to the HMO. Therefore, costs can be predicted based on prospective capitated payment.
Eligibility Groups Included in STAR+PLUS
Enrollment Groups

Enrollment in STAR+PLUS is mandatory for some and voluntary for others.

Let’s look first at consumers who must receive services through STAR+PLUS.
Mandatory STAR+PLUS Groups include:

- Supplemental Security Income (SSI) consumers age 21 or older,
- Medicaid Buy-In (MBI),
- Community Based Alternatives (CBA) waiver consumers, and
- Consumers eligible because they are in a Social Security exclusion program such as:
  - SAVERR Type Program 03 – Pickle Amendment Program,
  - SAVERR Type Program 18 – Disabled Adult Children Program, and
  - SAVERR Type Program 22 – Widow/Widower Program.
Voluntary STAR+PLUS Groups

The following groups may enroll in STAR+PLUS as voluntary members:

- SSI-eligible children (under age 21)
- Children (under age 21) who are Medicaid eligible because they are receiving a Social Security exclusion program
Excluded Groups

There are some groups who are excluded from using the STAR+PLUS model.

Let’s look at some of these groups in more detail.
Excluded Groups

- Persons in institutional settings
  - Nursing facility
  - Intermediate Care Facilities for persons with Mental Retardation or a Related Condition (ICF-MR/RC)
  - Institutes for Mental Disease (State Hospitals)

Keep going to see other excluded groups.
Excluded Groups

- Persons enrolled in a waiver program other than the 1915 (c) CBA waiver program:
  - Community Living Assistance and Support Services (CLASS)
  - Medically Dependent Children’s Program (MDCP)
  - Home and Community-based Services (HCS)
  - Consolidated Waiver Program (CWP)
  - Texas Home Living Waiver (TxHmL)
  - Deaf-Blind Multiple Disabilities (DB-MD)

- Individuals not eligible for full Medicaid benefits (e.g., Qualified Medicare Beneficiaries)
- Children in State Foster Care
Changes in Case Management

- DADS Case Managers are no longer the case managers for STAR+PLUS consumers. Consumers of LTSS in STAR+PLUS will have a service coordinator who is an HMO employee.

- If the care coordinator and the consumer decide to add 1915(c) nursing facility waiver services, the HMO will complete the assessment and will obtain needed medical necessity.
Reassessment of Eligibility

- Functional reassessments for STAR+PLUS consumers are handled by the HMOs. Financial reassessments are determined by the HHSC Office of Eligibility Services (OES) and are coordinated by the STAR+PLUS support staff defined on the next page.
STAR+PLUS Services Unit

- There is a DADS STAR+PLUS Support Unit in each service area who handles functions that the HMOs do not have the authority to handle regarding waiver services, (e.g. approval or denial of waiver services can only be done by a state agency.)

- More information will be shared on the functions of these units in future courses.
Let’s Review…

- All SSI consumers in the expansion counties are considered mandatory enrollees of STAR+PLUS.

True or False
Let’s Review…

- All SSI consumers in the expansion counties are considered mandatory enrollees of STAR+PLUS.

True or False

This is false.

There are SSI consumers who are not mandatory enrollees, such as those on 1915(c) waiver programs that are STAR+PLUS excluded eligibility groups. Examples are Community Living Assistance and Support Services (CLASS) and Home and Community-based Services (HCS).
Let’s Review…

- Community Care Case Managers no longer determine eligibility for CBA consumers and no longer conduct annual reassessments for CBA consumers.

True or False
Let’s Review…

- Community Care Case Managers no longer determine eligibility for CBA consumers and no longer conduct annual reassessments for CBA consumers.

  True or False

This is true. The case management is handled by the HMOs.
Congratulations!

You have completed the Getting to Know STAR+PLUS Computer Based Training (CBT).

DADS Staff: To receive credit for the Course, you must take a short Quiz. Click the DADS button below to exit the course and return to PALMS.

In PALMS: Click on the Take Quiz button to take the quiz.

Providers: Click the Provider button to complete the evaluation.
Providers - Please print the evaluation and complete each item with your choice of: Strongly Agree, Agree, Disagree or Strongly Disagree. Thank you for your input.

The information in this course was clearly explained.
The course contained the right amount of information.
The tone and style of the course was appropriate.
CBT was an effective way for me to learn this material.

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